J-1 VISA PHYSICIAN TRANSFER NOTIFICATION FORM INSTRUCTIONS

PURPOSE

The purpose of this form is to notify the Primary Care Office and US Department of State of change in employment location of J-1 VISA Physicians placed by the Primary Care Office.

INSTRUCTIONS

J-1 VISA Physicians placed by the Primary Care Office (PCO) and a representative of the new sponsoring medical facility for the J-1 VISA Physician (who has transferred from the initial approved sponsoring medical facility practice site) should complete (and have notarized) and submit the form to the Primary Care Office within 60 days after employment begins at the new practice site location.

The following should be provided on the form:

Section I
Place check in type of J-1 VISA Program.

J-1 VISA Physician should provide contact information in Section I. Information includes physician name, complete home address, and home telephone number.

Section II
J-1 VISA Physician should provide the following for the former sponsoring medical facility practice site: facility name, complete address, telephone number, county location, and HPSA information.

Section III
J-1 VISA Physician should provide the following for the new sponsoring medical facility practice site: facility name, complete address, telephone number, county location, and HPSA information.

Section IV
J-1 VISA Physician must certify currently working 40 hours per work providing health services at new sponsoring medical facility practice site listed in Section III **(must be notarized)**

Section V
Representative of new sponsoring medical facility must certify when J-1 VISA Physician began working at new site and that J-1 Physician is working 40 hours per week providing health services at new sponsoring medical facility practice site **(must be notarized).**

OFFICE MECHANICS AND FILING

This form is required to be completed by the J-1 Physician and a representative of the new sponsoring medical facility of the J-1 Physician and must be notarized. The form is returned to the PCO and a copy is sent to the US Department of State and is placed in the J-1 Physician's file.

RETENTION PERIOD

The J-1 Physician file is kept in the PCO for seven years.

J-1 VISA PHYSICIAN TRANSFER NOTIFICATION FORM

SECTION I

Conrad State 30 ☐ ARC ☐

J-1 PHYSICIAN NAME: _____

COMPLETE HOME ADDRESS: _____

Street City State Zip code

HOME PHONE: (_____) _____

SECTION II

FORMER SPONSORING MEDICAL FACILITY INFORMATION:

Name of Former Sponsoring Medical Facility: _____

Complete Address: _____

Street City State Zip Code

County: _____ **HPSA Location:** _____

Phone: _____

Date of Transfer: _____

SECTION III

NEW SPONSORING MEDICAL FACILITY INFORMATION:

New Sponsoring Medical Facility Name: _____

Complete Address: _____

Street City State Zip Code

County: _____ **HPSA Location:** _____

Phone: _____

SECTION IV

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE NEW LOCATION STATED, A MINIMUM OF 40 HOURS PER WEEK.

_____ _____

J-1 VISA Physician's Signature **Date**

(Notary)

SECTION V

I DO HEREBY CERTIFY DOCTOR _____ **BEGAN PRACTICING**

AT _____ **ON** _____ **AND PROVIDES PRIMARY**

HEALTH CARE SERVICES AT THE NEW HPSA LOCATION A MINIMUM OF 40 HOURS PER WEEK.

_____ _____

Sponsoring Medical Facility Representative (Please Print) **Title of Facility Representative**

_____ _____

Representative Signature **Date**

(Notary)

RETURN THIS FORM BY MAIL TO THE FOLLOWING:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH & PRIMARY CARE
570 EAST WOODROW WILSON - P. O. BOX 1700
JACKSON, MISSISSIPPI 39215-1700
TELEPHONE #: 601-576-7216